Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of $815.00 for date of service, 8/06/01.

   b. The request was received on 8/6/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60 and Letter Requesting Dispute Resolution
   b. HCFA(s)
   c. EOB/TWCC 62 forms/Medical Audit summary
   d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   a. TWCC 60 and/or Response to a Request for Dispute Resolution
   b. HCFA(s)
   c. Medical Audit summary/EOB/TWCC 62 form
   d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 9/11/02. Per Rule 133.307 (g) (4), the Carrier representative signed for the copy on 9/12/02. The response from the insurance carrier was received in the Division on 9/19/02. The insurance carrier's response is timely.

4. Notice of Additional Information Submitted by Requestor is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Letter dated 9/06/02

   "….the insurance carrier only paid us $300.00 total for codes E0731, L0565 and L0960 out of $1,115.00 that was billed for these items. Since there is no MAR for codes E0731

(Mesh Back Brace), L0565 (Lumbar Brace) and L0960 (Lordotic Pads), we have enclosed EOBs from other insurance carriers that have reimbursed us for these same codes. These EOBs should clearly prove and state that we are only asking to get reimbursed what is 'fair and reasonable' per our geographical area as TWCC Medical Fee Guidelines state….In summary, we strongly feel and believe that we should be reimbursed an additional $815.00 plus interest since the EOBs enclosed clearly reflect what other insurance carriers are paying as 'fair and reasonable' in our geographical area."

2. Respondent: Letter dated 9/19/02
"….ACCORDING TO PAGE 254 OF THE 1996 FEE GUIDELINES, DME SHALL BE REIMBURSED AT 'FAIR AND REASONABLE [SIC] THE SAME AS THE 'D' CODES IN THE 1991 FEE GUIDELINES. THE CARRIER HAS PAID THE PROVIDER BASED ON CODES FOR THE PURCHASE, AS OUTLINED IN THE 1991 FEE GUIDELINES. THEREFORE, NO ADDITIONAL REIMBURSEMENT IS WARRANTED…."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 8/06/01.

2. This decision is being written based on the documentation that was in the file at the time it was assigned to this Medical Dispute Resolution Officer.

3. Per the Requestor's Table of Disputed Services, the Requestor billed the Carrier $1,115.00 for services rendered on the above dates in dispute.

4. Per the Requestor's Table of Disputed Services, the Carrier paid the Requestor $300.00 for services rendered on the above dates in dispute.

5. The Carrier's EOBs deny additional reimbursement as "M – REDUCED TO FAIR AND REASONABLE; REASON: A STATEMENT OF MEDICAL NECESSITY, ALONG WITH THE ORDER OR PRESCRIPTION APPROPRIATE FOR THE EQUIPMENT/SUPPLIES SHALL ACCOMPANY INITIAL CLAIMS FOR THE RENTAL OR PURCHASE OF A DME, PER PAGE 254 OF THE TEXAS FEE GUIDELINE.; N – REIMBURSEMENT IS BEING WITHHELD PENDING DOCUMENTATION FROM THE TREATING PHYSICIAN REGARDING MEDICAL NECESSITY FOR THIS SERVICE."

6. Per the Requestor's Table of Disputed Services, the amount in dispute is $815.00 for services rendered on the above dates in dispute.

7. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MAR$ (Maximum Allowable Reimbursement)	REFERENCE	RATIONALE:
8/06/01 8/06/01 8/06/01	E0731-NU L0565-NU L0960-NU	$495.00 $495.00 $125.00	$150.00 $150.00 $0.00	M M N	DOP for all dates of service	MFG GI VIII	MFG GI VIII states "…NOTE: TWCC modifiers may differ from those published by the American Medical Association, and in submitting workers' compensation billing, only the modifiers set out in this Medical Fee Guideline shall be used…" According to the HCFAs submitted by the Provider, they billed using the -NU modifier. This modifier is not recognized in the '96 MFG. For this reason, the Medical Review Division is unable to determine proper reimbursement. Since "-NU" is an unrecognized modifier, **no** additional reimbursement is recommended.
Totals		$1,115.00	$300.00				The Requestor **is not** entitled to reimbursement

The above Findings and Decision are hereby issued this 11th day of April 2003.

Pat DeVries
Medical Dispute Resolution Officer
Medical Review Division

PD/pd